STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CO A. BUILDING B. WING STREET	ONSTRUCTION  00  ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 02/27/2012
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	606 WA	ALL ST RAISO, IN 46383	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00103996.  Complaint IN00103996 Substantiated, Federal/State deficiencies related to the allegations are cited at F 241, F309, F441 and F 498.  Survey dates: February 26, and 27, 2012  Facility number: 000083 Provider number: 155166 Aim number: 100289670  Survey team: Sandra Haws RN  Census bed type: SNF/NF: 150 Total: 150  Census payor type: Medicare: 17 Medicaid: 121 Other: 12 Total: 150  Sample: 5 Supplemental sample: 4  These deficiencies also reflect State findings cited in accordance with 410 IAC	F0000	The creation and submission this Plan of Correction does n constitute an admission by thi provider of any conclusion set forth in the statement of deficiencies, or of any violatio regulation.  This provider respectfully requests that the 2567 Plan or Correction be considered the Letter of Credible Allegation a requests a post survey revisit or after March 14, 2012.	ot s : n of f

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/27/2012	
	PROVIDER OR SUPPLIE	R REHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383	
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E COMPLETION
	16.2.				
	Quality review of Cathy Emswille	completed 2/29/12 r RN			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet

Page 2 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00 COM		TED
		155166	B. WIN			02/27/2	012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			606 WA			
VALPAR	AISO CARE AND R	EHABILITATION CENTER			RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0241 SS=E	in a manner and maintains or enh	promote care for residents in an environment that ances each resident's dignity II recognition of his or her					
	individuality.  Based on observative record review the resident's call light timely manner learned up to an hour or toileting and care residents reviewed sample of 5 (Resfor 4 of 4 resident	ation, interviews and e facility failed to ensure hts were answered in a aving residents wait for longer for assistance with	F02	41	F241 DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care residents in a manner and in a environment that maintains or enhances each resident's dign and respect in full recognition his or her individuality.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	for in hity of	03/14/2012
	at 4:20 p.m. an o Resident # B's ca were observed pa ignoring the light was observed pad alert staff to assis During an intervi- family member a his mother waits the staff to come	bservation was made of all light on. Three staff assing the resident's room t. Resident #B's family cing the hall trying to			ractice  The call lights are now being answered as promptly a possible. Our goal is to answered all lights within 15 minutes or less.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take  All residents have the potential to be affected by the alleged deficient practice.  All staff will be educated the answering of call lights by SDC/designee by 3/13/12.	al n	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet Page 3 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DINC	00	COMPLETED
		155166		LDING		02/27/2012
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	₹				
	4100 04DE 4ND E	SELLABILITATION OF STEE		606 WA		
VALPAR	AISO CARE AND F	REHABILITATION CENTER		VALPA	RAISO, IN 46383	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	come to visit, he	has found his mother			· The call lights are now	
	laying in stool and urine.				being answered as expeditiou	sly
					as feasible.	
	During an interview on 2/26/12 at 4:30					
	_				What measures will be put in	nto
	_	er family member who			place or what systemic	
	visited regularly	.regarding the resident's			changes you will make to	
	care, she indicate	ed she's been with the			ensure that the deficient	
	resident when sh	ne's had to wait over 30			practice does not recur  Call light studies will be	,
	minutes for some	eone to put her on the			completed daily ongoing on	
	bedpan.	r			rotating shifts. The	
	осирин.				ED/designee will review the	
	D				studies and action plans will	be
	_	riew with alert and			developed as needed.	
	oriented Resider	nt #B on 2/26/12 at 5:10			The Customer Care Rep	os
	p.m. she indicate	ed she waits 30 to 35			complete rounds daily during	
	minutes for her	call light to be answered.			normal business hours and wi	II .
	She stated "I ius	t can't hold it any longer			interview residents in regards	
	1	n I lay in poop and pee a			timeliness of call lights. Roun	
		my son's wife a lot so she			are reviewed twice daily (M-F)	
	_	-			Manager on duty during	
		help me." Resident #B's			business hours and charge nurses on all shifts will monito	r
		ved to have a clock on the			call light response times on	1
	resident's microv	wave visible to the			weekends to ensure call lights	are
	resident.				answered promptly.	
					The Unit Managers during	ng
	Resident #B's re	cord was reviewed on			normal business hours and the	
		o.m. The resident's record			charge nurses will monitor cal	
		eses of, but not limited to;			light response times Monday -	
	1				Friday to ensure call lights are	•
		ire, diabetes, congestive			answered promptly.  Staff found by	
	-	akness and chronic			management/nursing staff to b	ne
	airway obstruction	on.			passing by and not answering	
					lights will be disciplined up to	
	The resident's re	cord indicated she was			including termination.	
		nary tract infection on				
		rinalysis dated 2/20/12			How the corrective action(s) w	vill
		•			be monitored to ensure the	
	indicated the res	ident's urine color was			deficient practice will not recui	r. l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	a. Building 00			COMPLETED	
		155166	B. WIN			02/27/2	2012	
			F		ADDRESS, CITY, STATE, ZIP CODE	1		
NAME OF I	PROVIDER OR SUPPLIE	R		606 WA				
	AISO CARE AND I	REHABILITATION CENTER			RAISO, IN 46383			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG		+	DATE	
		dy. The white blood cell			i.e., what quality assurance program will be put into place			
		umerous to count, the			Program will be put little place			
		rine was 4+ (high.)			The ED/designee will re	view		
	A physician's or	der dated 2/21/12			results of all call light studies			
	indicated "(unle	gible name of antibiotic)			•	ven		
	300 mg (milligr	ams) 1 po (by mouth) x			days a week. Action plans w	III be		
	(times) 10 days	for UTI (urinary tract			developed and additional  education will be given			
	infection) twice	` •			when the 95% threshold is no			
	, , , , ,	-			obtained.			
	Resident # B's o	uarterly MDS (Minimum			· Managers will review the	ne		
					Customer Care Reps rounds			
	Data Set) assessment dated 2/19/12 indicated the resident's cognition was				twice daily (M-F). Information	n will		
		•			be presented to the CQI committee for review and			
	1	red total assistance with 2			monitoring.			
		s and bed mobility. She						
		e assistance with dressing						
		e MDS indicated the						
		easional incontinence of						
	bowel and blade	ler function.						
	1	erview with alert and						
	oriented Resider	nt # C on 2/26/12 at 6:40						
	p.m. regarding h	nis call light being						
	answered timely	y, he indicated many times						
	he has to wait up	p to 2 hours before they						
	1	ther indicated many times						
		me in to his room and turn						
		tell him they would be						
	back and they no	•						
	Jack and they in	ever return.						
	Resident # C's r	ecord was reviewed on						
	2/27/12 at 12:00	p.m. The resident's						
		diagnoses of, but not						
		iplegia, depression,						
		ection, and neurogenic						
		conon, una nourogenia						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet

Page 5 of 24

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CO  A. BUILDING	00	COM	TE SURVEY MPLETED 27/2012
			B. WING	ADDRESS CITY STATE ZIP CO		_ · · <b>_ · · _</b>
NAME OF I	PROVIDER OR SUPPLIE	R	606 WA	ADDRESS, CITY, STATE, ZIP CO ALL ST	NE	
VALPAR	AISO CARE AND F	REHABILITATION CENTER		RAISO, IN 46383		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG	,	NCY MUST BE PERCEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION DATE
TAG	bladder.	R LSC IDENTIFYING INFORMATION)	TAG	DEI TELET.		DATE
	Diaddel.					
	Resident #C's au	uarterly MDS assessment				
	_	ndicated the resident's				
		tact, he needed total				
		2 staff for transfers and				
		e needed extensive				
	1	dressing. The MDS				
		ident had frequent				
		his bowel function.				
		mis oo wer random.				
	3. Resident #'D's	s record was reviewed on				
		p.m. The resident's				
		diagnoses of, but not				
		ness, diabetes, kidney				
	disease, and dep	· · · · · · · · · · · · · · · · · · ·				
	Resident # D's s	ignificant change MDS				
	assessment dated	d 2/16/12 indicated she				
	had only slight i	mpairment with				
	cognition. She n	eeded total assistance				
	with 2 staff for t	ransfers and bed mobility.				
	She had occasion	nal incontinence of her				
	bowel function.					
	_	riew with alert and				
		nt #D on 2/27/12 at 2:00				
		er call light being				
	1	, she indicated she waits				
		. She stated "I have a				
	· ·	en I need to have a bowel				
		vait is terrible and I can't				
	, ,	g." She further indicated				
	she's complained	d about how long it takes				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet

Page 6 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155166	B. WIN	G		02/27/2012
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SOLI EIER			606 WA	LL ST	
VALPAR	AISO CARE AND R	EHABILITATION CENTER		VALPA	RAISO, IN 46383	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	•	ner, but it doesn't get				
	better.					
		rview with alert and				
		t #G on 2/26/12 at 5:20				
		er call light being				
		, she stated " I wait over				
		when I need to use the				
		rait that long." She further				
		s the staff just pass by				
	her door and not come in when her light is					
	on.					
		cord was reviewed on				
	2/27/12 at 3:00 p	.m. The resident's record				
	indicated diagnos	ses of, but not limited to;				
	Hypertension, di	abetes and				
	cerebrovascular a	accident. The resident's				
	record indicated	she was treated for a				
	urinary tract infe	ction within the last 60				
	days.					
	The resident's qu	arterly MDS assessment				
	dated 1/9/12 indi	cated the resident's				
	cognition was in	tact. She needed				
	extensive assista	nce with 2 staff for bed				
	mobility, transfer	rs, toilet use and hygiene.				
	The resident need	ded extensive assistance				
	with dressing and	d ambulation. The MDS				
		ident was occasionally				
		r bladder function and				
		nt of bowel function.				
	5. During an inte	rview with alert and				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet Page 7 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00			ETED
		155166	B. WIN	IG		02/27/	2012
NAME OF P	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				606 WA			
VALPAR	AISO CARE AND R	EHABILITATION CENTER		VALPAF	RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		t # H on 2/26/12 at 5:25					
	1	er call light being					
		. The resident stated "I've					
		r and I had an accident in					
	*	I couldn't hold it any					
		me they are short of help					
	and that's why th	ey can't get to me."					
	Resident # H ind	icated she's waited 15					
	minutes before the	ney finally come in to					
	clean her up.						
	Resident #H's red	cord was reviewed on					
	2/27/12 at 3:30 p	o.m. The resident's record					
	indicated diagno	ses of, but not limited to;					
	Cerebrovascular	accident (stroke),					
		art failure and anemia.					
	Resident # H's 30	0 day MDS assessment					
	dated 1/9/12 indi	cated her cognition was					
	intact, she neede	d total assistance with 2					
	or more staff for	bed mobility, toilet use					
	and hygiene, she	needed total assistance					
		and dressing. The					
		extensive assistance with					
		ers. The MDS indicated					
		occasionally incontinent					
	of her bowel fun	-					
	or nor cower run	<del></del>					
	6 During an inte	erview with alert and					
	1	t # I on 2/26/12 at 5:40					
		is call light being					
	1	, he indicated he waits					
		for it to be answered and					
	it's too long to W	ait. Resident # I indicated					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet Page 8 of 24

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE ( COMPL		
		155166	A. BUI B. WIN	LDING		02/27/	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	R		606 WA			
VALPAR	AISO CARE AND R	REHABILITATION CENTER		VALPA	RAISO, IN 46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	LAN OF CORRECTION	
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		ng worse, it happens on		mo	·		DATE
	all the shifts.	ing worse, it happens on					
	Resident # I's red	cord was reviewed on					
	2/27/12 at 3:45 p	o.m. The resident's record					
		ses of, but not limited to;					
		nic bladder and heart					
		lent's annual MDS					
		1 1/4/12 indicated her					
		tact. He needed total c or more staff for bed					
		rs, dressing, toilet use					
	1	e resident needed total					
	assistance with e						
		ident had an indwelling					
		always incontinent of					
	bowel function.	•					
	1	erview with alert and					
		at # J on 2/26/12 at 6:00					
		er call light being					
		, she stated "I wait for up					
		es. I've messed myself in					
		uldn't wait any longer, it's " She further indicated					
	_	r when they clean her up.					
	The care was poo	i when they clean her up.					
	Resident # J's red	cord was reviewed on					
		o.m. The resident's record					
	_	ses of, but not limited to;					
	Asthma, chronic	obstructive pulmonary					
	disease (COPD),	seizures, diabetes and					
	heart failure.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet

Page 9 of 24

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	00	(X3) DATE SURVEY  COMPLETED		
MIDILAN	155166	A. BUILDING		02/27/2012		
	100100	B. WING	ADDRESS OF A STATE OF	32/21/2012		
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE			
VALPAR	AISO CARE AND REHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	I	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	The resident's quarterly MDS assessment					
	dated 2/23/12 indicated her cognition was					
	intact, she needed extensive assistance					
	with 2 staff for bed mobility. She needed					
	total assistance with 2 or more staff for					
	her toileting needs and extensive					
	assistance with hygiene and dressing. The					
	MDS indicated the resident was					
	incontinent of bowel and bladder					
	function.					
	The resident's plan of care dated 11/30/11					
	indicated "Problem; Resident is					
	frequently incontinent of bowel and					
	bladderApproachAssist with					
	incontinent care as neededOffer bedpan					
	routinely and as needed"					
	The facility's policy titled "Certified					
	Nursing Assistant" updated 5/08 was					
	reviewed on 2/27/12 at 4:10 p.m. The					
	policy indicated "Responds to every					
	signal light and buzzer promptly (within 5					
	minutes of first ring) and courteously					
	considering each light as an emergency					
	until answered"					
	This Federal tag relates to Complaint #					
	IN00103996					
	3.1-3(t)					
		•		•		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet

Page 10 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155166	A. BUILDING 02/2			COMPLETED 02/27/2012
		133100	B. WIN		A DDDDGG GITTY GT ATE TID GODE	02/21/2012
NAME OF P	PROVIDER OR SUPPLIER			606 WA	ADDRESS, CITY, STATE, ZIP CODE	
	AISO CARE AND R	EHABILITATION CENTER			RAISO, IN 46383	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
		LSC IDENTIFFING INFORMATION)		TAG	BELIEBRELY	DATE
F0309 SS=D	WELL BEING Each resident m must provide the services to attair practicable phys psychosocial we the comprehensi care. Based on observer record review, the care was provide skin from develor	Il-being, in accordance with the assessment and plan of ation, interviews and the facility failed to ensure at to prevent a resident's ping further excoriated	F03	09	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary of and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	e
	Findings include	e in a sample of 5 : Resident #B's room on			What corrective action(s) wil be accomplished for those residents found to have beer affected by the deficient practice	
	made of CNA #. Resident # B ont #B was observed her buttocks. The of her buttocks w An observation w reddened open an and one open red size to the right w interview with L was watching CN assist the residen	o.m. an observation was and CNA # 4 assisting to the bedpan. Resident to have 3 open areas to the skin area to both sides was dark purple in color. Was made of 2 dime size the reas to the left buttock to the left buttock. During an PN # 2 at that time who was and CNA # 4 tt, she indicated she the resident having any			Resident B is currently receiving Xenaderm as prescribed and the areas are healing.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take  All residents have the potential to be affected by the alleged deficient practice.  All residents that currently resi in the facility have received a through and accurate skin	n

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet

Page 11 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155166				02/27/2	2012
			B. WIN		ADDRESS OFTW STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
				606 WA			
VALPAR	AISO CARE AND F	REHABILITATION CENTER		VALPA	RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	open areas to her	r bottom. LPN # 2 left the			assessment	]	
	room at that time	e. Resident #B was			· Skin checks will be		
	observed velling	"My butt hurts so bad"			completed on all residents twice		
		wiped her bottom of open			weekly during bathing. The ai	de	
		•			will report any abnormal skin findings to the charge nurse. T	-ho	
		was observed to take a			charge nurse will assess the	i ie	
	• •	ion ointment that was			resident and notify the physicia	an I	
	located on the re	sident's bedside table			as indicated.		
	with a label that	read Xenaderm ( used to			<ul> <li>Nursing staff will be</li> </ul>		
	treat pressure uld	cers) and apply a heavy			educated on skin assessments	-	
	amount to the re	sidents excoriated and			the SDC/designee by 3/13/12.		
	open areas on he	er buttocks.			Posttest will be given.		
					\A/\. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
	During on interv	iew with alert and			What measures will be put in	το	
	_				place or what systemic changes you will make to		
		nt #B on 2/26/12 at 4:50			ensure that the deficient		
		er pain, she indicated the			practice does not recur		
	sores on her bott	om were extremely			practice accentication.		
	painful.				· Unit Manager/designee	will	
					audit the Daily Observation re		
	During an interv	iew with the Director of			in clinical meeting (Mon-Fri) fo		
	_	/12 at 5:40 p.m. regarding			change in resident condition.	Any	
		pen areas, she indicated			resident with a change of		
	^	e Resident #B had any			condition will be reviewed for		
		•			appropriate intervention and documentation.		
	_	further indicated the			Nursing staff will be		
		on the resident earlier had			educated on skin assessments	s;	
		ed and shouldn't have			nursing assistants will be		
	been in the resid	ent's room or used on the			educated on notifying the char	ge	
	resident.				nurse of changes in skin		
					condition and applying		
	Resident #R's red	cord was reviewed on			appropriate ointments by the		
		o.m. The resident's record			SDC/designee by 3/13/12. Posttest will be given.		
	_				Nursing assistants will be given.	ne l	
	_	ses of, but not limited to;			educated on their job descripti		
		ire, diabetes, congestive			and operating within the scope		
	· ·	akness and chronic			practice by the SDC/designee		
	airway obstruction	on.			3/13/12.	<b>1</b>	

		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED
		155166	B. WIN			02/27/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		606 WA		
VALPAR	AISO CARE AND F	REHABILITATION CENTER			RAISO, IN 46383	
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG		DATE
					Nurses will check skin	4
	Resident #B's in	itial admission MDS			areas during showers/bed bath	n at
	(Minimum Data	Set) assessment dated			least twice weekly.  How the corrective action(s)	
	10/13/11 indicat	ted the resident was			will be monitored to ensure t	he
	admitted withou	t any open areas.			deficient practice will not rec	
		o unity open uneug.			i.e., what quality assurance	,
	Resident # B's q	uarterly MDS assessment			program will be put into plac	e
	^	dicated the resident's			· A "Skin Management	
	cognition was in	stact and required total			Program" CQI tool will be utiliz	red
	_	2 staff for transfers and			weekly x 4, then monthly	
		he needed extensive			thereafter.	
	_				<ul> <li>Data will be submitted to</li> </ul>	0
		dressing and bathing. The			the CQI Committee for review	
	MDS indicated t				and follow up.	
		ntinence of bowel and			Noncompliance with facility	
	bladder function	. The MDS indicated no			procedures may result in disciplinary action	
	open areas.				disciplinary action	
	A physician's or	der dated 1/27/12				
		Kenaderm to buttocks				
		orn (as needed) for				
	soilage."					
	A physician's or	der dated 2/8/12 indicated				
		e) tx (treatment) to				
	,	, · · · ,				
	-	olved, apply nystatin				
		ks every shift and for				
	soilage."					
	An IDT (interdic	sciplinary) note dated				
	*	"IDT met to discuss skin				
		occyx presents resolved.				
		lat (bilateral) buttocks				
	possible yeast ra	ash presents red				
	satellite"					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		A. BUII	DING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/27/2012		
		100100	B. WIN		PROPERTY OF THE CORE	02/21/2012	
NAME OF I	PROVIDER OR SUPPLIE	₹		606 WA	DDRESS, CITY, STATE, ZIP CODE		
	AISO CARE AND F	REHABILITATION CENTER			RAISO, IN 46383		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL  R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETI DATE	iON
IAU	REGULATORT OR	CESC IDENTIFTING INFORMATION)		IAG		DATE	
	A CNA shower:	report dated 2/22/12					
		iation to buttocks, no					
	pressure areas						
	pressure areas						
	The resident's sk	rin sheets titled "Skin					
	integrity Events.	Non-Pressure Wound					
	Skin Evaluation	Report dated 2/23/12					
	indicated "rash	n, R (right) buttock 2.0 x					
2.0, color red, wound/skin condition							
status: sc (subcutaneous)"							
	The resident's sk	tin sheets titled "Skin					
	integrity Events.	Non-Pressure Wound					
	Skin Evaluation	Report dated 2/23/12					
		n, L (left) buttock 4.0 x					
		vound/skin condition					
	status: sc (subcu	taneous)"					
	Review of Nurse	es' note dated 2/26/12					
	documented at 6	:00 p.m. indicated LPN #					
	2 made an entry	to indicate the Xenaderm					
	ointment was red	ordered by the physician					
	for the resident's	open areas identified					
	earlier that even	ing when the resident was					
	being assisted w	ith her toileting needs at					
	4:40 p.m.						
	A care plan date	d 1/17/12 indicated "					
	_	ent name) is at risk for					
	`	kdown frequently					
		owel and bladder and					
		obility and use of					
		n cream to buttocks every					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet Page 14 of 24

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

	DF CORRECTION IDENTIFICATION 155166		A. BUILDING  B. WING	00	COMPLETED 02/27/2012			
	ROVIDER OR SUPPLIER AISO CARE AND REHABILITA	TION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE PI REGULATORY OR LSC IDENTIFY	ERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	shift and as neededpreven treatment as ordered."	atative						
	This Federal tag relates to C IN00103996	omplaint #						
	3.1-37(a)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet Page 15 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED			
		155166	A. BUILDING		02/27/2012		
		100.00	B. WING	ADDRESS OF A STATE SID CODE			
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE			
\/ALDAD	AISO CADE AND D	EHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383				
VALPARA	AISO CARE AND R	EHABILITATION CENTER	VALPA	RAISO, IN 46363			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0441	483.65						
SS=D		NTROL, PREVENT					
	SPREAD, LINEN	establish and maintain an					
		Program designed to					
		anitary and comfortable					
		I to help prevent the					
		d transmission of disease					
and infection.  (a) Infection Control Program  The facility must establish an Infection  Control Program under which it -							
	•	controls, and prevents					
	infections in the	•					
		t procedures, such as					
		be applied to an individual					
	resident; and						
	(3) Maintains a r	ecord of incidents and					
	corrective action	s related to infections.					
	(b) Preventing S	pread of Infection					
		ection Control Program					
	determines that	a resident needs isolation to					
		ad of infection, the facility					
	must isolate the						
		ust prohibit employees with a					
		isease or infected skin					
		ct contact with residents or contact will transmit the					
	disease.	ct contact will transmit the					
		ust require staff to wash their					
		direct resident contact for					
	which hand wasl	hing is indicated by accepted					
	professional prac	ctice.					
	(a) Linana						
	(c) Linens	handle, store, process and					
transport linens so as to prevent the spread of infection.							
		ation, interview and	F0441	F441 INFECTION CONTROL,	03/14/2012		
				PREVENT SPREAD, LINENS	55/11/2012		
	record review, th	ne facility failed to ensure					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet

Page 16 of 24

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE  A. BUILDING	CONSTRUCTION 00	(X3) DATE : COMPL	ETED	
		100100	B. WING		02/27/	ZU 1Z	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  606 WALL ST  VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) practices were followed	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRIDEFICIENCY)  The facility must establish	D BE OPRIATE	(X5) COMPLETION DATE	
	related to handward # 3) leaving a beet the bathroom flowith stool splatte toilet and floor in shared by other ranot implementing control practice range resident's soiled by the stool of	dpan soiled with stool on or, an unflushed toilet red on the back of the a bathroom that was esidents and for 1 CNA g the correct infection elated to cleaning a bedpan (CNA # 6) for 1 viewed for infection		maintain an Infection Comprogram designed to provide safe, sanitary and comfort environment and to help puthe development and transmission of disease an infection.  What corrective action(side be accomplished for the residents found to have been affected by deficient practice	trol ride a rable prevent  nd  will se the		
	on 2/26/12 at 4:4 was made of CN assisting Resident # bowel movement was observed to and quickly exit.  On 2/26/12 at 45 made of Resident toilet water was observed on the bowel movement was observed on the brown stool cover Liquid brown stool splattered on the	of Resident #B's room 0 p.m. an observation IA #3 and CNA # 4 It #B onto the bedpan. B was finished having a finished having was bathroom; The observed to be full of finished having most of the bedpan. For was observed to be back of the toilet, the lide toilet. The bathroom		The nursing assistanow properly washing their per standard of practice, be are now being sanitized at toilets are being flushed a cleaned appropriately.  How will you identify other residents having the potential satisfied and what correcting action will be taken  All residents have the potential to be effected by alleged deficient practice.  All staff will be educt hand washing by the SDC/designee by 3/13/12 posttest was given.  Nursing staff will be educated on the procedurate cleaning resident equipment the SDC/designee by 3/13 posttest was given.	ir hands pedpans nd nd  htial to leficient ve  he tated on A e for ent by		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155166	B. WING		02/27/2012	
NAME OF T	DROLUDED OF GUIDAL TOP		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		606 W	ALL ST		
		EHABILITATION CENTER		RAISO, IN 46383		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	TE COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG		BATE	
		served to have dime size		What measures will be put int		
	brown stool drip	spots.		place or what systemic changes you will make to ensure that the		
				deficient practice does not rec		
	_	iew with CNA # 3 at 5:20				
	p.m. regarding th	ne way the resident's		· Hand washing skills		
	bathroom was le	ft, she indicated the toilet		validations/observations will b		
	wouldn't flush ar	nd she was in a hurry to		completed weekly on all shifts the SDC/designee ongoing.	by	
	get a resident to	the dining room. CNA #		Sanitation		
	_	athroom was shared by 2		validation/observations audits	will	
other residents. CNA # 3 flushed the toilet again, the toilet was observed to flush normally. CNA # 3 was then observed to take the soiled bedpan with				be completed weekly on all sh	nifts	
				by the SDC/designee		
				ongoing.		
				<ul> <li>Customer Care Reps during normal business hours</li> </ul>		
	brown stool, put water in it from the			Nurses on all shifts and Nursi	•	
	_			Managers during normal		
		om sink, swish it and put		business hours will make rour		
		NA # 3 dried the bedpan,		daily to monitor hand washing		
	_	e basket and left the		bathroom sanitation, call lights responses and equipment	5	
	room without wa	shing her hands.		cleaning and storage. Any		
	\			deficiencies noted will be		
		cord was reviewed on		documented on the rounds sh	eet	
	2/26/12 at 7:30 p	o.m. The resident's record		and education will be provided	d	
	indicated diagno	ses of, but not limited to;		immediately to staff.		
	Acute renal failu	re, diabetes, congestive		All staff will be educated hand washing by the	u	
	heart failure, wea	akness and chronic		SDC/designee by 3/13/12. A		
	airway obstruction	on.		posttest was given.		
				· Nursing staff will be		
	2. During a tour	of the facility on 2/27/12		educated on the procedure fo		
	_	observation was made of		cleaning resident equipment to the SDC/designee by 3/13/12		
		ret paper towel with stool		posttest was given.	. ^	
	_	trash. CNA # 6 was		F-3.000 3110111		
	_	an unbagged bedpan in a		How the corrective action(s) w	<i>i</i> ll	
	resident's bottom			be monitored to ensure the		
	resident's bottom	i diawer.		deficient practice will not recu	r,	
				i.e., what quality assurance		
	During an interv	iew with CNA # 6 at this		program will be put into place		

i ´		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	00	COMPL	ETED
		155166	B. WING			02/27/	2012
NAME OF I				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	K		606 WA	LL ST		
VALPAR	AISO CARE AND F	REHABILITATION CENTER		VALPAF	RAISO, IN 46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		ow she cleans the			· The "Infection Control" a	and	
	•	ns after use. CNA # 6			"Hand Washing "and "Sanitation		
		resident has a BM (bowel			Validation" CQI audit tool will b		
	· ·	takes a paper towel with			completed weekly by the		
	_	sident's bathroom and			SDC/designee ongoing.	_	
	•	es it then stores it in the			Data will be submitted to the CQI Committee for review		
	resident's botton	n drawer.			and follow up.		
					Noncompliance with fac	ility	
	During an interv	riew with the Director of			procedures may result in		
	Nursing on 2/27/12 at 3:10 p.m. regarding the above infection control issues, she				disciplinary action.		
	indicated the staff will need inserviced as						
	this isn't the way	it's to be done.					
	The facility's po	licy and procedure titled					
	"Nursing" undat	ed was reviewed on					
	2/27/12 at 10:00	a.m. the policy indicated					
	"b. Bedside pe	ersonal equipment, such as					
	commode, urina	ls, wash basin, emesis					
		lpan, shall be maintained					
	in a sanitary con	dition. This shall include:					
	i. Emptying con	tent in toilet, ii. Place					
		t in plastic bag, iii. Take					
	• •	t to soiled utility room,					
	• •	s, v. Clean disinfect					
	_	facility guidelines, vi.					
		and perform hand					
	_	ce cleaned/ disinfected					
		ean plastic bag, viii.					
		disinfected equipment to					
	resident room						
	This Federal tag	relates to Complaint #					
	IN00103996	10.000 to Complaint !!					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet Page 19 of 24

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155166	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMP	ESURVEY LETED 7/2012		
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
	3.1-18(a)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet

Page 20 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
		155166	B. WING		02/27/2012	
	PROVIDER OR SUPPLIE AISO CARE AND F	REHABILITATION CENTER	606 W	ADDRESS, CITY, STATE, ZIP CODE ALL ST ARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F0498 SS=D	able to demonst techniques needs as identi assessments, as care.  Based on observing record review, the staff worked with related to a CNA Assistant) apply medication that a resident's skin areas for 1 of 3 pressure ulcers in #B) (CNA #3)  Findings included During a tour of on 2/26/12 at 4:4 was made of CNA #3 was made of CNA #3 wiped CNA #3 wiped CNA #3 was observed to have buttocks. Residuyelling "My buttocks. Residuyelling "My buttocks." A was observed to have buttocks as wiped CNA #3 was observed to have buttocks. Residuyelling "My buttocks." Residuyelling "My buttocks." A was observed to have buttocks. Residuyelling "My buttocks." Residuyelling "My buttocks." A was observed to have buttocks. Residuyelling "My buttocks." Residuyelling "My buttocks." A was observed to have buttocks. Residuyelling "My buttocks." Residuyelling "My buttocks." A was observed to have buttocks. Residuyelling "My buttocks." Residuyelling "My buttocks.	/CARE NEEDS It ensure that nurse aides are trate competency in skills and essary to care for residents' fied through resident and described in the plan of tration, interview and the facility failed to ensure thin their scope of practice and (Certified Nursing ing prescription had been discontinued to excoriation with open resident's reviewed with a sample of 5. (Resident	F0498	F498 NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in si and techniques necessary to of for residents' needs, as identif through resident assessments and described in the plan of car  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice  Nursing assistant #3 understands her scope of practice and will not apply prescription medications.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take  Residents residing in th facility have the potential to be affected by the alleged deficie practice.	kills care fied s, are.  I n	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C60411

Facility ID: 000083

If continuation sheet

Page 21 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	A. BUILDING 00		COMPLE	TED
		155166	B. WIN			02/27/2	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER		606 WA			
\/AI DAD	AISO CAPE AND	REHABILITATION CENTER			RAISO, IN 46383		
	AIGO CAINE AIND	REHABIEITATION CENTER		VALIA			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	open areas and	the surrounding skin.			Resident rooms were		
					checked for medications at		
	During an inter-	view with CNA # 3 at that			bedside without physician's		
	_	a CNA allowed to apply			orders. Any medication found was then removed.		
		dication to a resident's			Nursing assistants will be	ne l	
					educated on their job descripti		
	_	stated "yes, we do it all			and operating within the scope		
	the time."				practice by the SDC/designee	by	
	During on inter	view with the Director of			3/13/12. What measures will be put in	to	
	During an interview with the Director of Nursing on 2/26/12 at 5:40 p.m. regarding				place or what systemic		
					changes you will make to		
CNA #3 applying prescription medication					ensure that the deficient		
	to Resident # B's excoriated open areas,				practice does not recur		
	she indicated a	CNA is not allowed to					
	apply prescripti	on ointment to any			<ul> <li>During daily rounds on a</li> </ul>	all	
		ds as it's not in their scope			shifts the charge nurses and		
		further indicated she			nursing managers during norm		
	_	esident #B had any open			business hours will observe th		
		esident #B nad any open			nursing assistants for compliant and document on the Nursing	nce	
	areas.				Rounds checklist.		
					· The DNS/designee will		
		view with alert and			review the Nursing Rounds		
	oriented Reside	nt #B on 2/26/12 at 4:50			checklists daily for compliance	).	
	p.m. regarding	her pain, she indicated the			· Resident rooms are		
	sores on her bot	ttom were extremely			checked daily for medications	at	
	painful.	-			bedside without physician's		
	F				orders. Any medication found then be removed.	WIII	
	During an inter	view with the Director of			Nursing assistants will b	ne	
	_	6/12 at 5:40 p.m. regarding			educated on their job descripti		
	_	1 0 0			and operating within the scope		
		kin excoriation and open			practice by the SDC/designee		
	•	ated she wasn't aware			3/13/12.		
		d any open areas. She					
	further indicated	d the Xenaderm used on			Llow the corrective action (-)	au	
	the resident ear	lier had been discontinued			How the corrective action(s) w be monitored to ensure the	''''	
	and shouldn't ha	ave been in the resident's			deficient practice will not recur		
	room or used or				i.e., what quality assurance	'	
1			1		, , , , , , , , , , , , , , , , , , , ,		

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	A. BUII	LDING	ONSTRUCTION 00	(X3) DATE COMPL <b>02/27</b>	ETED
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE  606 WALL ST  VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E	(X5) COMPLETION DATE
	2/26/12 at 7:30 p indicated diagnor. Acute renal failure, were airway obstruction. A physician's order indicated "3 X every shift and p soilage."  A physician's order D/C (discontinued coccyx area resourceam to buttock soilage."  During an intervent Nursing on 2/27/brought in an em #3 read and signs handbooks rules.	der dated 1/27/12 denaderm to buttocks rn (as needed) for  der dated 2/8/12 indicated e) tx (treatment) to lved, apply nystatin s every shift and for  diew with the Director of description of the descrip			program will be put into place.  Data from the Nursing Rounds Checklist will be submitted to the CQI Comm for review and follow up.  Noncompliance with fi procedures may result in re-education and or disciplinaction.	ittee acility	
	11:00 a.m. titled Assistant" update "Seeks assistan	"Certified Nursing ed 5/08 indicated nurse when ment, procedure, or					

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Event ID: C60411

Facility ID: 000083

If continuation sheet

Page 23 of 24

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	of CORRECTION IDENTIFICATION N  155166	UMBER:	x2) MULTIPLE CO.  A. BUILDING  B. WING	00	COMPI 02/27	LETED		
	ROVIDER OR SUPPLIER  AISO CARE AND REHABILITATION	I CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFI (EACH DEFICIENCY MUST BE PERCE REGULATORY OR LSC IDENTIFYING I	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	This Federal tag relates to Comp IN00103996	blaint #						
	3.1-14(i)							

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Page 24 of 24